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there does not seem to be a difference of opinion between Penrod et al and ourselves regarding appropriate conclusions. It is encouraging that the more recent palliative care studies in our review tended to be of more rigorous methodology.

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International Nurse Migration and HIV/AIDS

To the Editor: The Commentary on health worker migration by Mr Gostin¹ rightly focused attention on nurses. Nurses are the backbone of primary care services in developing countries, particularly Africa. The rapid expansion of human immunodeficiency virus (HIV)/AIDS and tuberculosis has resulted in a major increase in nurses' workloads: in some parts of Africa, HIV/AIDS has doubled the patient load for nurses, with no commensurate improvement in salary or working conditions.²

The demands placed on nurses will likely increase with the current drive toward task shifting. Task shifting is a successful and necessary strategy to increase access to HIV/AIDS treatment in settings with severe human resource constraints. In particular, nurse initiation of antiretroviral therapy has allowed rapid expansion of treatment in settings where physicians are scarce.² Donors are showing a keen interest in task shifting for HIV care, and the President's Emergency Plan for AIDS Relief and World Health Organization are supporting research and implementation in this area.³ Nurses are expected both to take on new clinical responsibilities and to supervise lower cadres.

Task shifting and health worker migration must be tackled together. Focusing on task shifting alone may fail because many of Africa's nurses will have migrated to the United States and Europe.

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In Reply: Ms Lynch and colleagues draw attention to what I believe is the single most important challenge facing sub-Saharan Africa and other extremely poor regions. That problem is a generally weak public health and health care system that cannot meet the basic survival needs of the world's poorest and least healthy people.¹ Although donor states and philanthropies care passionately about crumbling health infrastructures in poor countries, they do little to solve the problem and they unwittingly contribute to it.

Rich countries contribute to the problem in at least 3 ways. First, donors want rapid, measurable successes so they invest in discrete disease-specific projects rather than in longer-term, sustainable solutions, such as building human resources. Second, they actually compete with domestic health services. By offering more lucrative salaries and attractive working conditions, donors make it harder for local government and businesses to retain physicians, nurses, and allied health professionals. Third, as my Commentary discussed, rich countries actively recruit or encourage health care professionals to leave their home countries for the prospects of substantially greater remuneration and a better life in Europe and North America. When these professionals migrate, moreover, developed countries pay little attention to how they can "give back" to source countries, such as by investing in training programs for physicians and nurses.

I believe that the international community does truly care about the world's poor. However, donor countries must recognize the real and urgent needs of the developing world, and the first need is to build strong, sustainable health systems with adequate numbers of well-trained health care professionals.

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